New Jersey Department of Health and Senior Services
Office of Emergency Medical Services

APPLICATION FOR LICENSURE:
MOBILITY ASSISTANCE, BASIC LIFE SUPPORT AND SPECIALTY CARE TRANSPORT PROVIDERS
NEW PROVIDER

1. Trade Name of Service (exactly as it will appear on the vehicle)

2. Type of Provider License Requested *(Check One Box Only)*

- ☐ Mobility Assistance Provider
- ☐ Basic Life Support Provider
- ☐ Specialty Care Transport Provider
- ☐ Mobility Assistance / Basic Life Support Provider
- ☐ Basic Life Support / Specialty Care Transport Provider
- ☐ Mobility Assistance / Basic Life Support / Specialty Care Transport Provider

3. Physical Address of Main Office

Street Address	Suite/Apartment Number
City, State, Zip Code	County

Name of Contact Person	Office Telephone No.	Mobile or Cell Telephone No.

4. Mailing Address

Address	PO Box Number or Suite Number
City, State, Zip Code	

5. Business Identification *(Check One Box Only)*

- ☐ Proprietorship (Single Owner-Not Incorporated)
- ☐ Partnership (Not Incorporated)
- ☐ Corporation (For Profit)
- ☐ Corporation (Non-Profit)
- ☐ Government Agency
- ☐ Other (Specify): _____

6. Medicaid Number	**7**. Medicare Number	**8**. FEIN Number

A **NON-REFUNDABLE** cashier's check or money order in the amount of **$1,500 or $1,250** must accompany this application.
Make the check or money order payable to: **"Treasurer State of New Jersey."**
(Government Agencies do not pay fees.)

(A through L companies pay $1,500 in ODD-numbered years and $1,250 in EVEN-numbered years;
M through Z companies pay $1,500 in EVEN-numbered years and $1,250 in ODD-numbered years.)

FOR STATE USE ONLY			
Date Received	Amount of Check	Check Number	Transmittal Number

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MOBILITY ASSISTANCE, BASIC LIFE SUPPORT AND SPECIALTY CARE TRANSPORT PROVIDERS
NEW PROVIDER (Continued)

1. Trade Name of Service (exactly as it will appear on the vehicle)			
9. Name and Address of Director			
Name (Last, First)		Title	
Address			Suite/Apartment Number
City, State, Zip Code			
Telephone Number	Fax Number	Mobile Telephone Number	E-Mail Address
10. Corporate Name and Address, if Different			
Corporate Name			
Address			Suite/Apartment Number
City, State, Zip Code			
Name of Contact Person		Telephone Number	Fax Number
11. Name and Address of Registered New Jersey Agent (Required if owners live or based in another state)			
Name (Last, First)		Title	
Address			Suite/Apartment Number
City, State, Zip Code			
Telephone Number	Fax Number	Mobile Telephone Number	E-Mail Address
12. Name and Address of Medical Director, if Providing BLS Emergency Response or SCTU Services			
Name (Last, First)		Title	
Address			Suite/Apartment Number
City, State, Zip Code			
Telephone Number	Fax Number	Mobile Telephone Number	E-Mail Address
13. Name of Specialty Care Coordinator, if Providing SCTU Services			
Name (Last, First)		Title	
Telephone Number	Fax Number	Mobile Telephone Number	E-Mail Address
License/Certification (Please Check) ☐ RN ☐ NR EMT-P ☐ NJ EMT-P		License/Certification Number	

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NEW PROVIDER (Continued)

1. Trade Name of Service (exactly as it will appear on the vehicle)	
14. Identify 100% of the Service Ownership in the appropriate section below. Attach additional sheets, if necessary.	
Proprietorships or Partnerships (Percentage of ownership shall total 100%.)	
14a. Name of Proprietor/Partner (Last, First)	Percentage of Ownership
Home Street Address	Social Security Number
City, State, Zip Code	Date of Birth
14b. Name of Proprietor/Partner (Last, First)	Percentage of Ownership
Home Street Address	Social Security Number
City, State, Zip Code	Date of Birth
14c. Name of Proprietor/Partner (Last, First)	Percentage of Ownership
Home Street Address	Social Security Number
City, State, Zip Code	Date of Birth
14d. Name of Proprietor/Partner (Last, First)	Percentage of Ownership
Home Street Address	Social Security Number
City, State, Zip Code	Date of Birth
14e. Name of Proprietor/Partner (Last, First)	Percentage of Ownership
Home Street Address	Social Security Number
City, State, Zip Code	Date of Birth

For additional owners, use additional pages if necessary.

15. Have you, any of the principals, owners, operators, managers, or any person mentioned in this application, **ever been suspended from Medicare or Medicaid, indicted for or convicted of Medicare or Medicaid fraud or any other crime?**

☐ No ☐ Yes

If yes, on an additional sheet, please give the person's name, title, and the details of the occurrence.

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NEW PROVIDER (Continued)

1. Trade Name of Service (exactly as it will appear on the vehicle)	
Use this Section for Corporations. Attach additional sheets, if necessary.	
16. Corporations **(List all persons/entities who own 1% or more of stock. Percentage of ownership shall total 100%.)**	
16a. Name of President (Last, First)	Percentage of Ownership
Home Street Address	Social Security Number
City, State, Zip Code	Date of Birth
16b. Name of Vice-President (Last, First)	Percentage of Ownership
Home Street Address	Social Security Number
City, State, Zip Code	Date of Birth
16c. Name of Treasurer (Last, First)	Percentage of Ownership
Home Street Address	Social Security Number
City, State, Zip Code	Date of Birth
16d. Name of Secretary (Last, First)	Percentage of Ownership
Home Street Address	Social Security Number
City, State, Zip Code	Date of Birth

For other percentage stockholders, use additional pages if necessary.

17. Have you, any of the principals, owners, operators, managers, or any person mentioned in this application, **ever been suspended from Medicare or Medicaid, indicted for or convicted of Medicare or Medicaid fraud or any other crime?**

☐ No ☐ Yes

If yes, on an additional sheet, please give the person's name, title, and the details of the occurrence.

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NEW PROVIDER (Continued)

1. Trade Name of Service (exactly as it will appear on the vehicle)

Answer every question. Attach additional sheets, if necessary, to give all required information.

18. Have you, any of the principals, owners, operators, managers, or any person mentioned in this application, ever owner, operated, managed or had a financial interest (directly or indirectly) in any of the following types of **services in New Jersey or in any other state?**

☐ No ☐ Yes

If yes, please identify:

☐ Taxi ☐ Ambulette ☐ BLS Ambulance ☐ SCTU

☐ Limo ☐ Invalid Coach ☐ ALS Ambulance ☐ Other Health Care Facility

☐ Livery ☐ Mobility Assistance Vehicle ☐ MICU

If yes to any of the above, on an additional sheet, please give the person's name, title, the trade name of the service and the address of the service. If the service was in multiple states, please list each service separately. List every state where the service organization operates.

19. Are you, any of the principals, owners, operators, managers, or any person mentioned in this application, **related** to a person who ever owned, operated, managed or had a financial interest (directly or indirectly) in **any of the following types of services in New Jersey or in any other state?**

☐ No ☐ Yes

If yes, please identify:

☐ Taxi ☐ Ambulette ☐ ALS Ambulance ☐ Any Other Business

☐ Limo ☐ Mobility Assistance Vehicle ☐ SCTU

☐ Livery ☐ BLS Ambulance ☐ Other Health Care Facility

If yes to any of the above, on an additional sheet, please give the person's name, title, the relationship, the trade name of the service and the address of the service. If the service was in multiple states, please list each service separately. List every state where the service organization operates.

20. Do you, any of the principals, owners, operators, managers, or any person mentioned in this application, hold an official position or office (Municipal/County/State/National elected or appointed official)?

☐ No ☐ Yes

If yes, on an additional sheet, give the person's name, title, position held and where.

21. Are any licensed vehicles going to storage at an address that is different than the main office?

☐ No ☐ Yes

If yes, on an additional sheet, please give the physical address of storage.

22. Are there any additional office locations that are different than the main office?

☐ No ☐ Yes

If yes, on an additional sheet, please give the address for the identified office.

23. Company Denied or Revoked: Have you, any of the principals, owners, operators, or managers, or any person mentioned in this application, ever owned, operated, managed or had a financial interest (directly or indirectly) in any application or license for any Taxi, Limo, Livery, Invalid Coach, Mobility Assistance Vehicle, Ambulette, Ambulance, any other health care facility or any other business which was denied, revoked, suspended, under indictment for, or convicted of Medicare and/or Medicaid fraud or any other crime?

☐ No ☐ Yes

If yes, give the person's name, title, trade name of the facility, the address of the facility and details.

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MOBILITY ASSISTANCE, BASIC LIFE SUPPORT AND SPECIALTY CARE TRANSPORT PROVIDERS
NEW PROVIDER (Continued)

1. Trade Name of Service (exactly as it will appear on the vehicle)	
24. List the Names of Additional Contacts/Officers. Attach additional sheets, if necessary.	
24a. Name (Last, First)	Title
Home Street Address	Social Security Number
City, State, Zip Code	Date of Birth
24b. Name (Last, First)	Title
Home Street Address	Social Security Number
City, State, Zip Code	Date of Birth
24c. Name (Last, First)	Title
Home Street Address	Social Security Number
City, State, Zip Code	Date of Birth

25. Will you provide Municipal (Street) EMS ambulance service?

☐ No ☐ Yes

If yes, on an additional sheet, please supply the following information for each municipality: Municipality Name, County, Hours and Days of Service, Whether the Agency Will Bill for Services, and the Effective Dates of Contract.

CERTIFICATION

The applicant certifies:

1. **that all data supplied in this application and any attachment is true and correct, to the best of his/her knowledge and believe and that willful misrepresentation of these facts may make the applicant subject to civil and/or criminal penalties;**
2. **that the application has been duly authorized by the full ownership and/or governing body of the applicant; and**
3. **that the service/facility has been/will be operated in accordance with applicable licensing requirements.**

Name of Applicant (Print) (Last, First)	Title
Signature	Date